Reducing Child Morbidity and Strengthening Health Care Systems in Malawi Project: Quarterly Report Number 5, April to June 2004

MSH Malawi

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Introduction

The MSH/ Malawi programme clocked one year of its existence in Malawi on May 11, 2004 which fell in the fifth quarter of its operations. It was a period of reflection and figuring the way forward as the programme increasingly gains focus through a good working relationship with counterparts in the MoH both at the central and district levels. It was also an opportune time as much of the programme's work fit into the 2004-2005 DIPs which were finalized during the same period. As stated in the Cooperative Agreement 690-A-00-03-0017-00, the programme's specific objectives are as follows:

- Improve prevention and management of childhood illnesses
- Increase use of malaria prevention practices
- Decentralize the health care system, and
- Strengthen central hospital management systems.

The MSH programme follows on the previous CHAPS project implemented in five districts of Malawi. The number of districts being supported in the current project has increased to eight – Mzimba, Kasungu, Salima, Ntcheu, Balaka, Mangochi, Mulanje and Chikwawa. Additionally, the project strengthens management of two central hospitals, Lilongwe and Queen Elizabeth (Blantyre), continuing but greatly increasing support previously provided by PHR Plus. The programme is being implemented by Management Sciences for Health (MSH) together with three implementing partners – the American Red Cross (together with the Malawi Red Cross Society), Health Partners of Southern Africa (HPSA), and Satellife.

Our operating principle remains that we follow our partners' lead in work planning, technical support, and financing. We work to improve the quality and efficiency of partner activities at all levels, but do not introduce or encourage activities which might be construed as outside the system. We have become increasingly active as our partnership with the MoH, districts and hospitals has strengthened.

The MoH Programme of Work (PoW) as well as the District Implementation Plans (DIPs) from the eight districts continued to guide the programme in defining, implementing and monitoring the various activities being implemented and planned for the coming financial year.

During the fifth quarter, MSH continued to provide technical and financial support for implementation of the 2003-2004 DIPs as well as the national Programme of Work. Notable examples of activities supported include:

- Strengthening Health Management Information Systems (HMIS) at facility, zone (sub-district) and district levels
- Support for development of the 2004-2005 DIPs in all eight districts
- Support to DHMTs to conduct Participatory Rural Appraisals (PRAs) and household surveys in selected focal villages

- Boosted performance of community drug and ITN access points through training of DRF and ITN Committees
- Support to child health initiatives that included IMCI ToTs and IMCI case management
- Support to malaria prevention activities, including promotion of IPT and ITNs
- Strengthening systems for HMIS, pharmacy, human capacity development, referral, quality assurance, supervision and community health
- Support to HIV/AIDS particularly VCT activities and stigma reduction
- Development and strengthening of various hospital management systems.

2.0 Routine operations at service delivery level

2.1 Support to Child Health

MSH supports the IMCI Secretariat, and Community IMCI Steering Committee and Technical Working Group in all three components of IMCI (facility treatment, management systems, and community). During the period under review, initiatives and interventions included:

- Participation in the Paediatric Hospital Quality of Care Improvement (PHI) initiative
- Review of low EPI coverage in Salima
- Child Health/IMCI Training of Trainers (ToT) for Chikwawa, Mangochi, Mulanje and Balaka
- Support to IMCI Case Management Training in Ntcheu and Mzimba.

The Programme's community component works closely with DEHOs to strengthen links between health facilities, HSAs, and community volunteers (especially those affiliated with the Malawi Red Cross Society). Significant progress was made by MSH's partners the Malawi Red Cross Society (MRCS) in implementation of the community health/ behaviour change component, including:

- Participatory Rural Appraisal (PRA) in Mulanje, Mangochi
- Initiatives to increase community drug access
- Training of ITN and DRF committees in Mulanje
- Facilitation of seed drug supply to DRFs in Chikwawa
- Educational Field Visit to Mwanza by Mulanje DHMT members, community members and MSH staff to learn about the C-IMCI experiences.
- Educational Field Visit to Chimteka village for HH/C-IMCI in Mchinji district by Salima Team
- Validation of formative research results
- Household survey to get baseline data for the community interventions in twenty villages of each of the programme districts.
- Induction of the Malawi Red Cross delegate.

2.1.1 Integrated management of childhood illness

Child Health / IMCI Training of Trainers (ToT): Since 2003, MSH has strengthened DHMT sustainability in several areas, including human resources DHMTs requested MSH assistance to train facility IMCI Coordinators. MSH supported training of seven IMCI facilitators from Chikwawa, Mangochi, Mulanje and Balaka. They are now expected to train facility staff in their respective districts.

IMCI Case Management Training: MSH provided technical and financial support for three IMCI case management trainings covering 20 clinicians in Ntcheu and 16 in Mzimba. Content included: assessing, classifying the sick child and identification of key problems and the appropriate management of the child; counseling of the mother or care taker, and follow-up care. Key areas of focus were: cough, fever, ear infections, anaemia, malnutrition, and malaria. As required by IMCI guidelines, post-training performance of participants will be assessed after six weeks.

Paediatric Hospital Quality of Care Improvement (PHI): MSH supports initiatives by the Quality Assurance Project (QAP) to improve quality of hospital care for children. During this period two MTAs and the Child Health Team Leader participated in a workshop at the Malaria Alert Center in Blantyre in support of Chikwawa, Mulanje and Ntcheu districts. The purpose was to disseminate key findings from the Assessment of the Quality of Care of Hospitalized Children in Malawi; use the findings to initiate a collaborative effort to improve paediatric hospital care; clarify improvement structures and gain support of hospital leaders for improving the quality of care for hospitalized children; and agree on the way forward.

Induction of the Malawi Red Cross delegate: The programme received a new delegate for the Malawi Red Cross component, Astrid Eisenlohr. The delegate visited the programme districts to introduce and familiarize herself with MSH/ Malawi Red Cross activities.

Initiatives to increase community drug access: The Community IMCI Steering Committee, as well as several DHMTs, requested MSH assistance for improving local access to SP, cotrimoxazole, and other essential medications. Malawi has made several attempts to increase access, including Drug Revolving Funds (DRFs), the Bakili Muluzi Health Initiative (BMHI), and Community IMCI drug kits (currently under pilot test). The first two are known to have many problems, however, and Community IMCI drug kits have not been tested. MSH will work with DHMTs, the C-IMCI Steering Committee, and the MoH to review and strengthen options for increasing access and to link them with community-based distribution of insecticide treated bed nets (ITNs).

In response to the request, MSH's partner the Malawi Red Cross Society (MRCS) instituted a task force to discuss the alternatives and sanction a consultancy which will look at all the issues surrounding the existing systems, including management systems, and come up with necessary recommendations. The scope of work has been finalized and discussions held with the proposed consultant.

Validation of formative research results: MRCS has completed formative research in Chikwawa, Mzimba and Salima to guide development of a behaviour change and communication strategy.

Household survey: The BCC strategy requires population based surveys to learn about actual practices in the households. This information will form the major baseline to be complemented by the formative research and the PRA. MSH and MRCS partners supported the DHMTs in carrying out a household survey in the selected twenty villages of Mzimba, Salima and Chikwawa. Results are expected in the following quarter.

Support to Participatory Rural Appraisal (PRA): MRCS, in collaboration with DHMTs, conducted PRAs in Mulanje, Mangochi, Mzimba, Kasungu, Salima, Chikwawa and Balaka to ensure that community strategies are based on current and evidence-based information. The PRA exercise involved focus group discussions and transect walks in the community, drawing village maps, and use of a questionnaire to interview adults and youths. At the end of this exercise feed back was given to the community.

Key recommendations emerging from PRA include:

<u>Health facility and referral</u>

- Establish or reactivate health center and community health committees
- Improve relationship between health center and community health committees, clarifying the roles and responsibilities of each
- Train volunteers/health workers and caretakers/parents in recognizing danger signs in pregnant women and children under five
- Establish an evacuation plan within communities to ensure quick transport of child or pregnant woman to health facilities; strengthen referral systems
- Use community events as a channel to disseminate health messages.

<u>Danger signs and treatment</u>

- Establish community drug access points, especially for ORS and SP
- Educate caretakers/parents to increase fluids during diarrhea and to promote breastfeeding
- Disseminate messages on malaria, pneumonia and diarrhea prevention and management
- Educate caretakers/parents on the importance of using the correct drug and dosage to treat malaria
- Promote exclusive breastfeeding for infants for at least the first six months of life.

<u>ITN use and antenatal care</u>

- Encourage women to seek ANC and promote use of SP
- Educate pregnant women on the importance and correct dosage of SP during pregnancy
- Educate community members about ITNs, including re-treatment
- Increase ITN supply.

Educational Field Visit to Mwanza by Mulanje Team: As a point of departure for C-IMCI , the Mulanje DHMT requested financial support to learn from colleagues in Mwanza regarding their experience, successes and problems being encountered. A ten member delegation comprising community members, MoH & MSH staff went to

Mwanza District. The group learned how communities had supported nutrition, and water protection and sanitation.

Educational Field Visit to Chimteka village for HH/C-IMCI in Mchinji district by Salima Team: A team comprising the CHTA, DHO, DEHO, HA, 3 HSAs, and IMCI Focal person, visited Chimteka village in Mchinji district to learn from counterparts how they have implemented C-IMCI activities. Two villages were visited after meeting with the District Technical Working Group. Members learned how activities such as HIV/AIDS prevention, orphanage, ITNS, sanitation, and early childhood care are well integrated. Communities also maintain and utilize data and extension workers work together.

Supply of Seed Drugs to DRFs in Chikwawa: Visits to communities and frequent discussions with the DHMT revealed the lack of community access to drugs as a serious problem. The MSH office discussed the issue with the DHMT, and once again the DHO showed his commitment by using district funds to provide seed drugs for four drug revolving funds (DRFs). Seed drugs included BB paint for scabies, abendazole, Tetracycline eye ointment, and calamine lotion. Fansidar was not supplied because it was out of stock at the district. However, the Pharmacy managed to provide two tins of Fansidar to each of the four DRFs later. Each committee has also been provided with fifty nets to sell to community members.

2.1.2 Expanded Programme of Immunization

Review of low EPI coverage in Salima: Supervision reports and HMIS data show that EPI coverage is very low in Salima. The MoH/ MSH baseline assessment also revealed frequent stock outs of vaccines in health facilities. Salima MSH staff and district EPI staff held a meeting to review the underlying factors contributing to the low coverage, including vaccine stock outs and lack of sensitization amongst stakeholders. MSH supported close supervision and sensitization of stakeholders to reduce these problems.

2.2 Support the National Malaria Control Programme

During this quarter, support for malaria control activities from the central office focused mainly on promotion of Intermittent Presumptive Treatment (IPT) and insecticide treated mosquito nets (ITNs). Major activities included:

- Development of an ITN training manual for community health workers
- Support for ITN and DRF training in Mzimba
- Procurement and distribution of ORT equipment
- Support to Malaria Case Management Training in Chikwawa
- Support to community based ITN distribution committees in Salima.

REAPING Mission: MSH participated in discussions aimed at assessing the level of achievement of the Abuja Targets relating to Roll Back Malaria. Participation in the series of meeting assisted the REAPING Mission team to identify successes and limitations; these helped in the formulation of appropriate recommendations for accelerating malaria control in Malawi.

2.2.1 Early recognition and prompt effective treatment of malaria

Malaria Case Management Training: In response to Chikwawa DHMT's request on the need for staff to be trained in malaria case management, MSH supported training of twenty health workers from the various health facilities in the district. Each health facility now has at least one staff member trained in malaria case management.

2.2.2 Presumptive intermittent treatment of all pregnant women

Development of Training Manual: The NMCP and individual districts are moving to increase coverage for the second dose of SP in pregnancy. MSH supported the NMCP to review the generic JHIEPIGO IPT training materials. With partial MSH support, the NMCP developed and pretested a draft training manual for IPT. The manual is intended to:

- Promote Focused Antenatal Care (ANC)
- Resolve practical difficulties in direct observation of IPT (DOTs)
- Facilitate access to and use of ITNs among pregnant women
- Improve behavior change communication among pregnant women
- Strengthen collection and use of appropriate data for monitoring activities
- Strengthen support supervision and problem solving approach for IPT.

IPT Problem Solving Meeting: MSH provided technical and financial support to representatives from Mangochi, Salima and Kasungu districts to participate in IPT related problem solving and solution identification. Participants prepared action plans aimed at addressing these problems. The same approach was extended to health facility staff of Balaka district. The discussions revealed the following as major factors inhibiting increased coverage of IPT:

- SP not given through DOTs
- ANC providers not clear on timing for SP doses
- Pregnant women starting ANC late
- CHAM facilities selling SP for the second dose
- Some health facilities in Balaka (Balaka Hospital Maternity Dept. and Chiyendausiku Health Centre) not providing ANC despite presence of appropriate equipment and staff
- Focused ANC (FANC) not practiced in health facilities
- Malaria in pregnancy data inadequately collected, used and reported.

In trying to address these problems, MSH procured and distributed IPT/ ORT equipment for all the eight districts. The equipment included 20 liter plastic buckets, 5 liter buckets, hand towels, 1 liter jug, table spoons, wooden spoons and tea spoons. In addition, each district developed action plans to address these problems.

Mzimba strategizes on Intermittent Presumptive Treatment: Mzimba malaria activities focused on increasing IPT coverage, which was found to be low (36%) during the facility baseline survey in October 2003. In an attempt to link malaria in pregnancy with HMIS and DIP monitoring, briefing sessions on IPT were incorporated into the

combined orientation of facility staff that took place in June. The orientation targeted health facility in-charges, HSA supervisors, and Zone Coordinators. IPT sessions took a problem solving approach where participants brainstormed on contributory factors to the low IPT coverage. Solutions were outlined with responsibilities for action assigned to various segments of a community, pregnant women themselves, husbands, parents-in-law, community, traditional healers, TBAs, schools etc. Some of the issues (reasons for low IPT coverage) raised were surprisingly broader than administration of SP or attendance of antenatal services by pregnant women:

- Lack of proper coordination at health facility
- Lack of appreciation of information
- Unavailability of data collection tools (forms)
- No health education schedules in health facilities/supervision
- No staff meetings in most health Facilities
- No interaction
- No information sharing

Participants generally felt that for IPT to be successful, mobilization should go beyond antenatal or health facility boundaries. Some structures that need to be enlisted for mobilization for IPT were identified as VHCs, churches, growth monitoring volunteers, traditional healers, counselors, TBAs, other extension workers, and party leaders.

2.2.3 Use of insecticide treated nets and other vector control measures

ITN Training Manual: In collaboration with the National Malaria Control Program, an ITN training manual for community health workers was drafted. The manual was pretested in Chikwawa and will be finalized in the following quarter.

Training Youth Organisation in community based distribution of ITNs in Salima, Makion Area: Through MSH support, nine members were trained in signs and symptoms of malaria; malaria prevention; roles and responsibilities, management of ITNs; treatment of ITNs, leadership and financial management, reporting and net procurement.

Training of ITN and DRF Committees In Mulanje: In response to the MoH National Malaria Coordinator who observed that committees were not been trained in ITN and DRF management, MSH supported Mulanje DHMT to train ITN and DRF Committees in two villages. Training was conducted from 12th – 16th April 2004. 24 participants attended, and 100 nets and drugs were distributed to each committee as starter packs from the DHO. Follow-up activities are expected in the coming quarter.

2.3 Support the National HIV/AIDS Programme

In keeping with its limited but specialized resources, MSH, the Malawi Red Cross Society, and the MoH continued to implement the programme's HIV strategy. Major activities during the period included:

- Support to HIV/AIDS referral workshops in Kasungu and Chikwawa

- Support to Stigma reduction workshops in Mulanje and Salima
- Support for the scale up of VCT services
- VCT systematization through the development and adoption of uniform referral forms in Chikwawa
- Recruitment of counselors for all the MSH Programme district hospitals
- Follow-up for outreach VCT sessions in Chikwawa
- VCT expansion meeting in conjunction with Umoyo Network
- Support to rollout of Cotrimoxazole therapy for HIV positive TB patients
- Support to HIV/AIDS national policy dissemination in Chikwawa

2.3.1 Voluntary Counseling and Testing

Scaling up of VCT service: Examples of MSH supported activities include:

- An assessment of requirements for VCT rooms was made in all eight district hospital VCT sites. Sixteen wooden demonstration penises were procured and put into use, and additional items will be purchased in the following quarter.
- MSH supported training for 20 VCT counselors from Chikwawa and Mulanje District hospitals, including 15 HSAs and five volunteers.
- The Chikwawa office supported outreach VCT services; however, progress was slowed by an inadequate number of HIV test kits. Central Medical Stores was closed for two weeks conducting stock taking, and nobody could access any drugs or supplies during the period. Twenty seven clients (eighteen males and nine females) were tested from which six (22 percent) were positive.
- MSH in conjunction with Umoyo Network organized a two day VCT expansion meeting for District AIDS Coordinators and Umoyo-supported NGOs. Meeting participants shared experiences and best practices.

Recruitment of counselors: Through discussions with senior MoH specialists, the MSH programme agreed to temporarily hire and second two VCT counselors for each of eight district hospitals. Counselors will be paid at approximately the same scale as HSAs; it is anticipated that the MoH will assume salary responsibility after two years. With the exception of Balaka, counselors were recruited for all the programme districts during the period under review.

2.3.2 Development of supportive health systems

HIV/AIDS referral workshops in Kasungu and Chikwawa: These workshops developed referral systems linking clients through the continuum of care to have access to VCT and other HIV/AIDS services. Twenty health care providers were trained, twelve in Chikwawa and eight in Kasungu. The following were the major findings and next steps:

<u>Major findings</u>

- Lack of feedback from the counseling site to the referral point
- Referred clients are not recorded
- Lack of continuum care for clients who have undergone Counseling and Testing
- Inconsistency in reporting of results
- Sometimes counselors are not available when clients are referred

- Referral of patients for counseling and testing is done verbally.

Next Steps

- Orient members of staff in the referral systems, and the benefits and availability of counseling and testing
- Design and place sign posts to inform people when and where VCT services are provided
- Provide hardcover notebooks to be used as registers in all wards and departments
- Procure file folders, boxes and locks for HIV test results.

Stigma reduction workshops in Mulanje and Salima: Twenty -one and twenty-four participants attended in Mulanje and Salima respectively. Workshop content included:

- Promiscuity and HIV/AIDS stigma
- Reluctance to know one's status
- HIV stigma and discrimination in the health care setting
- Rights of health workers and clients
- HIV transmission in the workplace
- Post exposure prophylaxis

The following recommendations were made to the DHMTs of Salima and Mulanje Mission hospitals:

- The draft government policy or a provisional policy developed by each facility on clients' and health workers' rights should be made accessible to staff and patients alike. The rights of marginalized groups, especially sex workers, to the highest quality of services need to be reinforced.
- Each facility should prioritize the drafting and dissemination of a policy (i.e. HIV/AIDS workplace policy) that clearly articulates good practices and repudiation for bad conduct in confidentiality, stigma and discrimination in the healthcare setting. The status, rights and responsibilities of HIV+ health workers needs to be made clear to all staff.
- Instituting a system where staff are rewarded/recognized for doing well in terms of respecting rights and fulfilling responsibilities should be considered.
- National VCT guidelines should be disseminated to staff, with special emphasis being put on issues relating to informed consent.
- The National ARV guidelines, including procedures for post exposure prophylaxis (PEP) need to be disseminated to staff. Facility-based PEP protocols should be developed and operationalized. As part of this, careful attention needs to be paid to establishing an appropriate and acceptable system of providing VCT to health workers in case of accidental exposure.
- Management should develop a system for ensuring that staff have access to continuing education during in-service training, staff meetings or regularly scheduled days for professional updates. The following topics should be prioritized: HIV transmission in the healthcare setting, management of occupational exposure including PEP, client and health workers' rights, issues relating to HIV counseling and testing, infection prevention and prevention of

occupational exposure, PMTCT and infant feeding, ARV therapy as well as positive living.

- Injection practices should be reviewed, and the proper use and disposal of needles and syringes reinforced.
- In Salima, the entire "climate of safety" should be examined to see where improvements can be made in staff support and supervision for maintaining proper infection prevention standards.
- Where community health education is being undertaken, anti-stigma messages can easily be integrated by training participants who now have the knowledge and skills to do so.

Rollout of Cotrimoxazole therapy for HIV positive TB patients: MSH in conjunction with the National TB program is rolling out Cotrimoxazole therapy in HIV positive TB patients. A one-day orientation was conducted for the MTAs, TB officers, counselors, District AIDS Coordinators, pharmacy technicians and laboratory technicians who will be implementing this program in Salima, Mangochi, Balaka, Mulanje and Chikwawa. The aim was to orient them on the entire management processes of the rollout of the cotrimoxazole therapy for HIV positive patients.

HIV/ AIDS National Policy Dissemination: In response to a DHMT request, MSH Chikwawa supported dissemination of the policy to all district hospital staff. The meeting was facilitated by staff from MANASO head office Blantyre.

3.0 Support for policy and planning

3.1 Strategic planning and policy development for hospital autonomy

Health Partners of Southern Africa (HPSA) continued to support efforts of the MoH Clinical Services Department in improving hospital management systems at Queen Elizabeth and Lilongwe Central Hospitals. Areas addressed included:

- Development of the strategic framework and implementation plan
- Revision of the Bill of Autonomy
- Strengthening Central Hospitals Management Information Systems
- Documentation of hospital management systems, including personnel management
- Establishing organizational structures based on cost centre management
- Strengthening accounting and revenue management systems
- Conducting financial reviews.
- Identification of key performance indicators used by hospital management teams and strengthening of the Health Management Information System
- Support strategic assessment of service delivery options (and decentralization of services)
- Support to JIP subcommittees
- Mentorship program for hospital directors.

3.1.1 Strategic framework and implementation plan

A Draft National Policy on Hospital Autonomy that brings together the main policies, plans and strategies for hospital autonomy drawn up by the Ministry over the past six years, was submitted to the Main JIP Committee early in May for consideration by senior officials from the MoH and donor partners. The draft policy was edited in the light of feedback from the JIP Committee and a revised draft policy is now complete and has been submitted to the MoH for approval. It is envisaged that this draft will be used as a departure point for wider consultation with stakeholders and drafting of a cabinet paper.

3.1.2 Bill on hospital autonomy

A Zero Draft Hospital Autonomy Bill was produced in July 2003 after the Legal Workshop in May 2003. This has been extensively revised in the light of the Draft Policy and a comprehensive new draft Version 1.1 has been submitted to the MoH for consideration together with a Briefing Paper outlining key policy issues that need to be resolved. Work has begun on development of additional legal instruments, including supporting regulations to accompany the Bill, and a draft Performance Management Agreement that will be entered into between the MoH and an Autonomous Hospital.

3.1.3 Strengthened central hospital management systems

Integrated performance management system (IPMS): Although discussions were held on data integration, data sets and formats, integration of information was not finalised. Development of basic IPMS structure was initiated, and in the next quarter work will commence on reporting outputs and integration of data sets.

Documentation of hospital management systems: The Hospital Management Strengthening Teams in both hospitals ran a second round of workshops where comments made to the documents were discussed and changes made to procedure documents (non-clinical services, clinical services and clinical support services). The next step is to bring together selected task team members from both hospitals to a workshop where documents produced at both hospitals will be reviewed and merged into single procedure documents. The intervention has already been rolled out to LCH, and it is anticipated that final documents will be produced in the next quarter as well as training for both management and staff.

Documentation of personnel management systems: Development work on new systems such as human resource plan, recruitment and retention strategy, disciplinary and grievance procedure, leave procedure, job descriptions, performance management system, registry system for both HR and mail and training and development has been completed. Implementation of some of the developed systems, such as registry, has already commenced at QECH. In the next quarter, HR records will be updated and computerised at both hospitals.

The development of a Human Resources Policy and Procedure Manual has progressed, with a second round of task team workshops where comments were made on the draft documents. The next step is to allow members from the two hospitals to sit together and merge their documents into one. This is planned for the beginning of the next quarter.

3.1.4 Improved hospital functioning

Establishing organizational structures based on cost centre management: The second draft cost centre organisation structures were developed and will be presented to the hospital management teams. The cost centres were linked with appropriate sub-programmes to enable effective reporting, with consideration of MoH and Treasury requirements. Some areas within these links need to be finalised. Staffing norms and theoretical resource allocation to cost centres was initiated, but needs to be finalised.

Accounting and revenue management systems: Strengthening of revenue management is being done through development and implementation of a revenue management model and revision of patient fees. A task team was commissioned by the JIP Subcommittee to revise hospital fees. The task team has completed costing of services and has simplified the fee structure based on costing bands. A comprehensive report was submitted to the MoH in June 2004.

The latest proposed patient fee structure submitted to the JIP finance committee was incorporated successfully into the revenue management tool, but required further revision due to the fact that it changed from the first draft proposed fee structure. The revenue model and revenue processes were workshopped successfully in both LCH and QECH. During these workshops, gaps in cash handling and patient identification were found and possible solutions developed.

Piloting of this intervention was scheduled for June 2004 but delayed until August because the MoH had not approved the new fee structure.

Financial Reviews: Financial reviews are integrated with budgeting for cost centres. The first draft financial review model is finalised and will be presented to hospital management during July. This includes the incorporation of the expenditure returns for the various sub programmes.

During the quarter, an external consultant in financial management was engaged to undertake a quick overview of financial management and accounting practices at QECH and LCH; and help managers to determine priorities for financial management reform and identify its strategic significance for improving management, performance, etc. A draft report is available on the findings. The next steps will be to put forward suggestions/options for suitable software for computerising the accounting systems and discussing with management/MoH. The consultant has also prepared a 1-year Plan of Action for taking forward reforms of the accounting and financial management systems (with computerisation), including determining the necessary inputs required.

This intervention will require support from both local and external financial technical assistance. Terms of reference are being drafted to support implementation of new accounting and financial management systems and to assist in selecting appropriate local technical (accounting) capacity. The consultant will also advise on integration of financial management reforms into the overall Malawi hospital autonomy initiative.

3.1.5 Key performance indicators used by hospital management teams, and strengthening of HMIS

Some progress has been made in strengthening HMIS in central hospitals and in conducting a survey of capacity in Lilongwe health centres. While most of the work has been undertaken at LCH, it is planned that during the next quarter, QECH will be visited and similar strategies developed.

A critical event during this period was the "Supervisory visit" conducted at Lilongwe Central Hospital with senior management from the MoH. This served to allow the MoH to reflect on the data set and quality of data. The following agreements were reached:

- Reduction of the data set to essential data elements
- Reporting requirements for units
- Use of midnight census data in wards
- Detailed exploration of data flow at Bottom Hospital.

The DHIS database has subsequently been customised to accommodate the individual reporting units arranged by cost centre, and each reporting unit has a specific set of data elements on which to report. Monthly reporting is being implemented, and it is anticipated that the first management reports will become available in the next quarter.

Another activity is an analysis of three months of anaesthesia data. This revealed interesting trends in utilisation of theatres (in particular high utilisation of Bottom Hospital theatres) and provided an overview of departmental usage and types of operations being performed. This data is extremely valuable for management and clinical purposes alike. Subsequent to this initial report, the data set has been adjusted to accommodate increased requirements for monitoring and evaluating anaesthesia, and was demonstrated to an anaesthetist at QECH with a view to it being implemented there as well.

The radiography data base was adjusted to accommodate from Bottom Hospital, and to provide a tool for combining the data from both units into a single report. Work on transport data base and management report has also been finalised.

3.1.6 Improved health systems functioning

Strategic assessment of service delivery options (and decentralisation of services): A strategic assessment of service delivery options is being undertaken to facilitate decentralisation of services from central hospitals to district health services. Interventions have been initiated to improve the efficiency of central hospitals by supporting devolution of primary care district health services. These include:

- A framework for planning decentralisation
- A district facility survey in Lilongwe to assess capacity to absorb additional workload, and
- A client survey in Blantyre.

All three surveys provide different perspectives of health service delivery and utilisation patterns in Lilongwe and Blantyre, to will inform decentralisation strategies.

During the survey of facilities in Lilongwe, an important process was initiated through the development of a questionnaire for health centres. Data collectors were trained, and the HMIS was used to capture data. The fact that the survey is in the HMIS means that this set of data elements can now be used in any other district in the country. In addition, the survey data serves to complement routine data, providing managers with a useful overview including routine and survey data. Currently, analysis of the data set (comprising about 43 clinics) is underway, and will be completed in July 2004.

Between April and May 2004, the Blantyre District Health Office implemented a client survey in order to establish the extent to which, and the reasons why, clients tend to bypass certain health facilities in favour of others. The survey also assessed the type of disease problems presented at the various levels, constructed user profiles, and explored health seeking behaviours and satisfaction with services. In addition, the survey also assessed the extent to which the referral system was working in the district. A draft report was completed in June and reviewed by the district decentralisation committee. Feedback and comments will be incorporated into a final report, and then findings will be disseminated during the next quarter. The survey has provided very useful information on why clients bypass district health facilities in favour of the central hospital. This will be used in formulating plans to facilitate greater decentralisation of services in the district.

3.1.7 Other activities

Appointment of long term technical assistants: The Hospital Management Technical Assistant (HMTA) for QECH resigned after working for only a month. Interviews for his replacement were conducted and a possible candidate identified. He is due to report for duties on 1st August 2004. Interviews for the post of Hospital Systems Development Specialist (HSDS) will be conducted towards the beginning of the next quarter. Several promising candidates have been shortlisted.

Support to JIP subcommittees: The programme facilitated one meeting and drafted the minutes of the JIP finance subcommittee on 17 June 2004.

Mentorship program for hospital directors: The director of Lilongwe Central Hospital spent a week shadowing his mentor at Johannesburg Hospital, getting useful exposure to a wide range of management activities. This gave him an opportunity to assess the composition and functioning of several hospital committees and to see how the CEO deals with difficult issues relating to resource allocation.

3.1.8 Important next steps

1) Seek approval of revised patient fees schedule.
2) Extensive stakeholder consultation on Hospital Autonomy Policy and Draft Bill.

3) Drafting of regulations to accompany the Hospital Autonomy Bill.
4) Formulation of a Performance Management Agreement between a Central Hospital and the Ministry of Health.
5) Formulation of a Memorandum of Understanding between a Central Hospital and an institution responsible for training and/or research.
6) Development of a Framework for Management of Health Related NGOs (involved in health service delivery and/or research).
7) Development of a Framework (Green Paper) for a Health Services Act.
8) Cabinet paper for Hospital Autonomy legislation.
9) Tabling of the Hospital Autonomy Bill in Parliament.
10) Development of financial management and accounting reforms for central hospitals including the introduction of a new computer based accounting system.
11) Continue with documentation of management systems at LCH and QECH.
12) Sensitize LCH staff to hospital autonomy through production of a regular bulletin.
13) Continue with interventions on decentralisation of management, strategic and operational planning and financial management.
14) Continue interventions on strengthening HMIS system.
15) Report on investigation done on accounting system for hospitals (Ike Osakwe).
16) Develop data flow policy for LCH
17) Develop reports for management and clinical departments at LCH
18) Expand reporting on data elements for clinicians at LCH
19) Develop data set for LCH pharmacy
20) Effect interface between DHIS and PMIS at LCH
21) Develop database for ICU patients at LCH
22) Customise the DHIS to suite reporting units at QECH
23) Provide support to QECH anaesthesia department
24) Conduct training on basic computer skills for staff at both hospitals and advanced DHIS course for the statisticians in the two hospitals and eight districts hospitals where MSH is working.
25) Line up activities on improving management of medical equipment at both hospitals
26) Develop action plans for developing specifications for equipment purchases

27) Develop guideline document on provision of laboratory services at both hospitals

28) Develop an action plan for strengthening quality of care in service delivery at both central hospitals

3.2 Development and review of District Implementation Plans

District Health Management Teams (DHMTs) are the centre point for MSH support. Apart from supporting DHMT extended meetings in the districts, MSH central and district-based staff continued collaborating with the DHMTs to support assessment of management systems and to identify priority actions for further development. Common needs identified during the DHMT needs assessment in Mangochi, Ntcheu and Mzimba were:

- Inadequate basic knowledge and skills in financial management among some DHMT members and accounting staff
- Transport policy available, but not fully explained to transport officers and other staff (health center in-charges, nurses, drivers, coordinators and DHMT members) and not implementing effective transport management
- Need for procurement of communication equipment, i.e. radios, e-mail and internet, source of power for radios, etc,
- Very few trained staff in handling HMIS at both the district and health center levels, and
- No use of DIP by Program Coordinators when implementing their activities (hence, failure to link activities to plans (DIP) and budget).

Support to Mzimba Extended DHMT: MSH facilitated a well attended one day Extended DHMT Meeting in Mzuzu. This was the third EDHMT meeting since December 2003. Specific tasks were to:

- Quickly review the current DIP
- Present and discuss partners' plans
- Discuss coordination of activities supported by various partners – with emphasis on July – September Plans
- Discuss a collaborative monitoring plan for the DIP
- Plan future meetings.

Participating NGOs submitted their quarterly plans for compilation by various district coordinators. The next meeting has been scheduled for 30 September at Ekwendeni mission; World Vision will look into financing.

4.0 Systems support at national and district levels

During the past quarter, MSH provided technical and financial support to strengthen planning and management systems, including:

- HMIS
- Pharmacy

- Human Capacity Development
- Referral Systems
- Quality Assurance
- Supervision

4.1 Implement a sector-wide Health Information System

MSH assisted the Health Management Information Unit (HMIU) to sponsor a national meeting to review HMIS progress and problems since its inception in January 2002. The meeting brought together Assistant Statisticians, HMIS Focal Persons, MSH Management Technical Assistants, the central HMIU staff, and MSH central office staff.

Specific outputs for MSH technical assistance include:

- Dissemination, implementation and supervision of national HMIS policy
- Identification and integration of vertical information systems
- Identification of priority indicators as a departure point for staff to use the data and monitor performance
- Support for timely and accurate reporting
- More effective use of quantitative information
- Initiation of a zonal level (sub-district) approach to HMIS supervision, including on-the-job training.

A full report of the workshop is in Annex 1.

Zonal Level (Sub-District) HMIS supervision: The national HMIS workshop revealed that inadequate supervision contributed to poor HMIS performance. A more cost-effective approach to supervision was proposed and pilot-tested in Mangochi and Mzimba. Results so far have shown that:

- The approach is more cost effective; staff are not taken to sleep out of their duty stations.
- The audience is manageable, allowing full participation.
- Staff have an opportunity to discuss problems, share experiences with counterparts from other health facilities, and discuss indicators of zonal performance.
- OJT and data audit (a means to check data accuracy) are conducted and skills imparted to supervisors.
- Initial steps on basic lessons in data use are demonstrated, followed by practical examples using their own data.

In essence, the zone (sub-district) approach in supporting health facility staff to conduct supervision is proving effective as it also links the DHMT and health facility staff. The model is described in full in Annex 1.

DHIS software training: DHIS software has several features for data manipulation. In discussions with DHMTs, it was realized that only the Assistant Statistician has basic skills to manipulate data. To support DHMTs in understanding and using data for

informed decision-making, MSH organized a three days training for all MTAs and CHTAs. Participants will use their skills to assist DHMT counterparts.

HMIS Quarterly Review in Chikwawa: The Chikwawa DHMT requested MSH to support a review of the performance of the district health indicators which are monitored through the HMIS. A gathering of Programme Coordinators, DHMT and health facility In-Charges reviewed the indicators through presentations by Programme Coordinators and the Assistant Statistician. However, it was noted during the discussions that the meeting was more beneficial for Programme Coordinators who dominated the meeting than the Health Centre staff. Secondly, because of the numerous indicators, it proved difficult for the audience to remain focused.

4.2 Pharmacy and medical supplies

MSH collaborates with counterparts and other partners at central and district levels in providing technical and financial support to strengthen the management of pharmaceutical and medical supplies. Notable achievements during the quarter were:

- Drug management training
- Supply Chain Management software training
- Re-organization of district pharmacies
- Support on the roll-out of ARVs.

During the quarter, Ralph Rack, an MSH pharmaceutical management consultant, visited Malawi. Ralph gave MSH-Malawi direction and advice regarding the pharmaceutical management. Talks were held with the MoH and JSI/Deliver on how these organizations can complement each other in their work.

Drug Management Training: In pursuance of one of the efforts of the MoH Health Technical Support Services, *"to properly manage pharmaceutical management program,"* MSH provided technical and financial support to the DHMTs to provide on the job training to health centre In-Charges in Salima, Mzimba and Mangochi. A total of sixty-nine health workers were trained. The trainings aimed to facilitate:

- Good storage practices.
- Proper record keeping
- Ordering of drugs and supplies
- Use of LMIS forms.

Supply Chain Management Software Training: MSH supports efforts to implement Supply Chain Manager (JSI/Deliver) to improve computerized stock management and timely ordering of drugs by district pharmacies. MSH in conjunction with JSI/Deliver trained eight Pharmacy Technicians and eight Administrative Assistants from the district MSH offices in supply chain management software. MSH then bought eight computers for the district pharmacies which were installed with the software and are in use.

Re-organization of district pharmacies: All district pharmacies except Mangochi were provided with technical support to re-organise pharmacies. The re-organisation involves

arranging drugs according to the dosage forms and in alphabetical order, putting labels on the shelves, and ensuring that each item has a stock card. So far, seven of eight district pharmacies have either completed re-arranging or have embarked on this exercise.

Roll out of ARVs: The MSH/MoH programme is a key supporter to the roll-out of ARVs. Discussions with the HIV/AIDS unit in the Ministry revealed lack of security in the district pharmacies for safe keeping of the ARVs. The following recommendations were agreed which MSH will support in the targeted districts:

- Provide lockable drug cabinets for ARVs and other drugs covered in the Dangerous Drugs Act
- Ensure that doors to the pharmacies have security locks and windows have burglar bars.
- Develop an inventory/ prescription system as with the Diflucan Programme currently being implemented in hospital pharmacies. The Diflucan register has already been adapted to suit the ARV requirements.

4.3 Strengthen Quality Assurance systems

- MSH supports quality improvement both in clinical areas (IMCI, infection prevention, pediatric hospital care, malaria control) and management (drugs, HMIS, use of human resources).

4.3.1 Facility level infection prevention and quality improvement

MSH has been supporting the reinforcement of infection prevention procedures in conjunction with JHPIEGO. Efforts include training, essential supplies, and supervision. Districts strive towards getting an aggregated score of 85 percent using the QA checklist. Major activities during the quarter include:

- Support to Mulanje and Salima in IP training for Health Workers on Infection Prevention
- Support for Performance and quality (PQI) in infection prevention
- Support for Baseline Infection Prevention Assessment to Mzimba DHMT.

Baseline Infection Prevention Assessment: Mzimba District Hospital qualified for participation in the MoH-endorsed Infection Prevention Initiative after training of a five-member core team in April and the prerequisite baseline survey in June. The five had joined colleagues from other hospitals at two training sessions conducted by JHPIEGO on *Performance and Quality Improvement in Infection Prevention* (PQI in IP). Their assigned task of briefing DHMT and the rest of hospital staff was well done, as demonstrated by the setting up of various Hospital IP committees soon after their training. The follow up baseline survey was led by a three person external assessment team from Mzuzu Central and St. John's hospitals which have already been accredited by MoH and JHPIEGO. The baseline results placed Mzimba District Hospital on a 21% starting point.

The DHMT, IP core team and IP Committee have shown signs of readiness to face the uphill battle head on! Plans were laid down for various training activities for the next quarter, beginning with support staff (ward and patient attendants, ground laborers and guards). Meanwhile, DHMT has been mobilizing materials and equipment for the initiative.

In Salima, 42 staff, including nurses, clinical officers, Lab, Dental and Radiography Technicians were trained in IP. Later 124 support staff were also trained, including hospital servants, laundry attendants, cooks, patient attendants, ward clerks, tailor, casualty assistant, laboratory assistant and ground laborers. Training covered:

- principles of IP
- disease transmission cycle
- use of antiseptics and disinfectant
- standard precautions
- instrument processing
- house keeping
- waste management
- traffic flow activities
- use of assessment tool

Performance and quality improvement (PQI) in infection prevention: MSH and JHPIEGO jointly provided financial and technical support for a training of health workers in PQI at Kambiri Lodge in Salima. The aim was to prepare the Quality Improvement support team to initiate a process of performance and quality improvement in IP in selected facilities. Seven selected districts (Salima, Mzimba, Mulanje, Chitipa, Karonga, Thyolo and Nkhata Bay) which are to implement PQI participated with five members representing each district. Objectives were to:

- promote PQI process and its implementation
- identify actual performance in infection prevention in selected facilities (District hospital)
- identify performance gaps
- conduct an initial cause analysis of the performance gap
- develop an operational action plan based on the baseline results focusing on rapid interventions
- learn how to monitor the process in the selected facilities.

The five participants from each district will form a quality improvement support team and work with the district to address issues of quality improvement in their respective facilities.

4.3.2 Strengthen integrated supervision of services

MSH has been assisting three MoH departments (Quality Assurance, Planning, and Preventive Health Services) to further develop and strengthen integrated supervision

systems. The Ministry's objective is to develop a framework within which supervision checklists can be used.

Supervision Problem Solving Work Sessions for Programme Coordinators and DHMT Members: MSH's goal is to assist the MoH to develop supervision policies and systems and to build capacity at national, zonal and district levels. MSH thus supported problem solving work sessions on supervision for Programme Coordinators and DHMT members of Chikwawa, Kasungu, Mulanje and Salima. Eighty four programme coordinators and DHMT representatives (22 from Chikwawa, 15 from Kasungu, 21 from Mulanje and 26 from Salima) participated. The sessions did a SWOT analysis of the current status of supervision and applied a problem solving approach to resolve the issues. A zonal (sub-district) model of supervision was discussed and tools and checklist examined to see if these could be used. A variety of approaches were used in the discussions including role plays, group discussions, and field trips.

Summary results of the reporting period were:

- Chikwawa district was sub-divided into six supervisory zones, and six supervisors were selected from among 25 program coordinators.
- Similarly, Mulanje district was sub-divided into four zones, with four supervisors and one district focal person selected from 24 coordinators. Each supervisor will take responsibility for approximately five facilities.
- Mulanje managed to supervise 40 percent of facilities within one month using the new approach, a substantial increase from the 6 percent covered in the October baseline survey.
- Both districts were oriented on how to write a supervisory report.

Analysis of the new supervision approach revealed the following:

- It is cost-effective, since only a few supervisors are needed and staff allowances and transport demands have been reduced.
- More health facilities are reached within a particular month.
- Issues requiring immediate action are addressed within a reasonable period as supervisors compete to ascertain that their zones are performing well.
- The time of coordinators is saved for other duties in the hospital.

The 'Red Flag' supervision checklist: The 'Red Flag' checklist is one of the checklists in the integrated supervision checklist used in the current supervision model that allows supervisors to isolate issues that require immediate attention in the health facilities. During the quarter under review, supervisors have managed to address several issues by using the red flag. Examples are as follows:

- Condoms, immunization vaccines and other essential drugs and supplies stock outs were immediately reported and deliveries made within a few days.
- Mulanje had health facility staff trained as counselors but were not practicing. The issue was resolved there and then for the counselor to start exercising her duties.

- Some health facilities were not recording in HMIS registers, OJT was provided immediately.

4.4 Strengthen other management systems

4.4.1 Human Resources

Several districts requested MSH assistance to increase the efficiency and effectiveness of existing health workers and managers, through clarified job descriptions, reinforced personnel appraisal systems and strengthened internal supervision (i.e., within specific facilities). During the past quarter the following were accomplished:

- Training Needs Assessments (TNA) conducted for several DHMTs
- Job descriptions updated and roles and responsibilities of DHMT members reviewed
- District and facility level staff returns developed in Mangochi.

Training Needs Assessment (TNA) for DHMTs: The activity was accomplished in Balaka, Salima, and Mzimba. The purpose was to orient DHMTs and their In-service Training Committee (ITC - where available), to the skills and knowledge needed to identify training requirements. The objective is to replace *ad hoc* with systematic approaches, enabling DHMTs to identify performance gaps, deficiencies, or problems, and to determine the most appropriate training and non-training interventions to improve worker performance. Results included a simple tool for recording the training needs of each incumbent and for monitoring training when it occurs.

Updating job descriptions and review of roles and responsibilities of the DHMTs: Undertaken in Chikwawa and Balaka, this activity oriented DHMTs to their roles and responsibilities as a management team for the district health delivery system. Achievements included:

- Developed list of roles and responsibilities for the DHMT Balaka;
- Recommended how the DHMT could use these to improve management
- Updated job descriptions for key positions.

Development of district and facility level staff return in Mangochi: Tracking of human resource information requires proper tools. Human resource data helps management to decide how to deploy staff in the right places at the right times and in the right numbers reflecting their workload. The Mangochi DHMT with technical support from MSH developed and started using a district staff return. This is intended to promote human resource management efficiency.

4.4.2 Implement financial management systems

In Mzimba a pilot in-depth TNA was conducted in the accounts section with a view to identifying specific training needs in accounting and financial management. This was to facilitate the design and development of an appropriate training and non-training interventions to address the identified needs and eliminate the observable problems in the Accounts Section at the DHO Mzimba. The assessment revealed the following:

- Inability of the Accounts Section to produce timely status reports to the DHMT on the financial position of the District Health Office
- Inability of all accounts staff to use the available computer for accounting purposes, i.e. reconciliation of accounts, production of returns, reports, through electronic records and system, etc.
- Identified instances of mis-postings, misallocations in the vote's ledgers, delays in reconciliation of accounts, losses of support documents for effecting payments, and lack of knowledge and skills in some processes and procedures.

Thus, the following interventions were recommended for immediate attention:

- Training of six Accounts staff in basic principles, procedures and practices in government accounting, including computer awareness/skills, bank reconciliations, expenditure returns and financial reports.
- Procuring two computers for the Accounts section.

The training sessions were scheduled for next quarter, at the district hospital.

Annex 1: GUIDELINES FOR CONDUCTING HMIS PERFORMANCE REVIEWS

The HMIS review and strategy development workshop held at Capital City Motel from 7th to 8th May discussed how we can effectively conduct HMIS performance reviews in the districts. A synopsis of the previous approaches of the reviews proved non-beneficial particularly to the health facility staff and the HSAs who play a crucial role as regards HMIS activities are concerned at the health facility/ district levels. Despite that the workshop did not exhaustively discuss the review process, the following guidelines are set to guide the process in the mean time:

1. First level emphasis will be at the Health Facility level. A half day Health Facility level review to be conducted at each health facility where the following are expected to occur:

    - A review of existing records/ registers
    - A random check of reported figures against recounts.
    - OJT on the new data elements contained in the revised registers
    - A review of the indicators (calculations and use) and discussions on performances e.g. immunization coverages, malaria incidence/ prevalence etc.
    - Timeliness and completeness of reports.
    - Data use
        i. Graph Drawing
        ii. Use of HMIS-13
    - How data is shared with other stakeholders.
    - Discussion of identified problems and action points.

2. To effectively accomplish the above, ensure the following:

    - Apart from the Assistant Statistician, a technical person from the district will be required to join the team to help interpret the results. The HMIS Focal Person would be the ideal person accompanied by the Zonal Coordinator.
    - For districts that are divided into Zones, there will be Zonal level HMIS reviews where the Health Facility In-Charges will be invited to review/ discuss Zone performance levels. A few Coordinators from the district should be invited to participate in these Zonal level performance reviews.
    - After the Zonal level performance reviews, there will be one and half days district level performance reviews where all Zone Coordinators will be invited to participate (thus all Health Facility In-Charges will be represented by these Zone Coordinators). At this forum, the DHMT and all Zone Coordinators and stakeholders will be required to attend. It is a requirement that the Assistant Statistician and the Focal Person discuss the Zonal level performance review

discussions with Programme Coordinators prior to the district level performance review discussions.

- Where there are no Zones, the health facility reviews will be followed by the district level reviews which are linked to the DIP reviews.

DISTRICT HOSPITAL LEVEL STAFF ORIENTATION

A two-day orientation be organized for district level staff, one for Clinical and nursing staff and another for Administrative staff to ensure that they appreciate the role of HMIS within the health system. This will also provide an opportunity for the other sub-systems (IFMIS, PPIMS, Transport etc) to recognize that they are part and parcel of the HMIS thereby ensure that the various data sets (sub-systems) are interacting and as such promoting efficiency in decision making by the managers in the districts.

District / Health Facility Monthly Reviews

Monthly reviews by health facility staff (including district hospital) and Programme Coordinators should be a continuous process to enhance data use and as a means of cultivating a culture of using information amongst health workers. The Assistant Statisticians and the HMIS Focal Persons should work as a team to ensure data is provided to the DHMT members, Programme Coordinators and all stakeholders whenever needed. While we anticipate the establishment of District HMIS Committees strong links should be developed with the District Planning Officer in the District Assembly so that they become a link in advocating for the use of the health information data in making decisions for the health sector in the district.

Central Level Support

The Central HMIU and MSH Central Office will provide the necessary technical support during the first week of facility level reviews particularly to guide the new areas where they have made changes in the registers and as well the indicators. Thereafter, the districts are expected to independently take charge of the activity.

Please note that these guidelines are not necessarily to frustrate your already committed plans but to help us support HMIS activities in the most cost-effective and sustainable way.

Hence, it is through these guidelines that I request all who raised HMIS budgets to review their budgets so that they are consistent with these guidelines.

Please note that these guidelines do not conclude the discussions at the HMIS Workshop held at Capital City Motel. Once the report is ready, you will be advised on the final recommendations.

Should you have any queries, please do not hesitate to contact Maxwell Moyo at the Central Office.

Remember, the bottom line is to make the Health Facility staff make good use of the data they collect, and empower them to act on the information for their day-to-day decision making. Let staff be able to reflect on the data and see the future before them. Thus improving the quality of data (completeness and accuracy) is paramount!